

MassHealth Application for Personal Care Attendant (PCA) Services

The PCA Agency is to complete and submit this application to MassHealth with all relevant documentation, including the request for prior approval. MassHealth may defer or deny incomplete applications.

Section I: Personal Care Agency

1	Agency Name:	2	Provider No.:
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Section II: Consumer Information

3	Consumer Name:	4	Birth Date:	5	Age:
		6	Date of Evaluation:	<input type="checkbox"/> Initial <input type="checkbox"/> Re-eval	
7	RID No.:	8	Site of Evaluation:		
9	Current Address:	10	Address for Service Delivery:		
	Telephone No.:		Telephone No.:		
11	Date of Initial Referral to PCA Agency: _____	12	For new applicants, the event that precipitated the request for PCA services:		
	Referral Source: _____				

Section III: Personal Care Attendant Services

13	Current PCA Schedule (Weekdays/Weekends):	14	Current PA No.: _____
15	Proposed PCA Schedule (Weekdays/Weekends):		Expiration Date: _____
16	Weekly Day/Evening PCA Hours Requested:	17	Weekly Night PCA Hours Requested:
18	Consumer's Legal Guardian's Name and Address:	Telephone No.:	
19	Living Arrangement (check all that apply):	20	Lives with (check all that apply):
<input type="checkbox"/> Lives with family <input type="checkbox"/> Lives independently <input type="checkbox"/> Transitional living <input type="checkbox"/> DMR (specify) <input type="checkbox"/> Foster home (specify) <input type="checkbox"/> Other, including other state-funded residential supports (specify):		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Spouse <input type="checkbox"/> Alone <input type="checkbox"/> Children (number and ages: _____) <input type="checkbox"/> Siblings (number: _____) <input type="checkbox"/> Roommates (number: _____) <input type="checkbox"/> Other (specify: _____)	
21	Are individuals in the home currently providing personal care to consumer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, provide documentation to explain why caregiver cannot continue to provide care — for example, documentation from the caregiver's physician as to the caregiver's diagnosis, disabilities, and limitations.			

MassHealth Application for Personal Care Attendant (PCA) Services (cont.)

22	Is the consumer receiving or about to receive any home-based services? <input type="checkbox"/> Yes <input type="checkbox"/> No																								
If yes, check all applicable boxes in items a through f below, enter the dates of service or projected start date, and indicate the number of hours and daily schedule.																									
a	Visiting Nurse <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule: _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">b</td> <td style="width: 30%;"> Continuous Skilled Nursing (Private Duty Nurse) <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule: _____ </td> <td style="width: 65%;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">c</td> <td style="width: 30%;"> Respite <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, identify funding source: _____ Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule: _____ </td> <td style="width: 65%;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">d</td> <td style="width: 30%;"> Other PCA or Homemaking Service (specify) <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule: _____ </td> <td style="width: 65%;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">e</td> <td style="width: 30%;"> Home Health Aide <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule: _____ </td> <td style="width: 65%;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">f</td> <td style="width: 30%;"> Other <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____ Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule: _____ </td> </tr> </table> </td> </tr> </table> </td> </tr> </table> </td> </tr> </table> </td> </tr> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">23</td> <td colspan="2"> Has consumer received PCA services from MassHealth in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, identify the following: <table style="width: 100%;"> <tr> <td style="width: 33%;">PCA Agency: _____</td> <td style="width: 33%;">Prior Auth. 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MassHealth Application for Personal Care Attendant (PCA) Services (cont.)

Section IV: Medical History

25	Primary diagnosis affecting functional status and warranting PCA Services:	26	Date of Onset:
		27	Height:
		28	Weight:
29	List medical history relevant to application for PCA Services, such as diagnoses, hospitalizations, and surgical procedures, and attach any recent supporting documentation, such as discharge summaries, home health care plans, etc.		
30	<p>Is consumer registered with Massachusetts Commission for the Blind? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is consumer receiving SSI/Blind benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If answer is yes to both questions, submit this application to:</p> <p style="text-align: center; margin-top: 20px;">Massachusetts Commission for the Blind 48 Boylston Street Boston, MA 02116-4718</p>		

MassHealth Application for Personal Care Attendant (PCA) Services (cont.)

Section V: Out-of-Home Activities)

31	Indicate activities that result in the consumer leaving home by checking all applicable boxes in items a through i below and entering program name (provider, employer, or school), the dates of service or projected start date, the name and telephone number of contact person, and the daily schedule.		
a	<input type="checkbox"/> Adult Day Health	Program: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____
b	<input type="checkbox"/> Day Habilitation	Program: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____
c	<input type="checkbox"/> Elder Services	Program: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____
d	<input type="checkbox"/> DMH-Contracted	Program: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____
e	<input type="checkbox"/> DMR-Contracted	Program: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____
f	<input type="checkbox"/> DSS-Contracted Services	Program: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____
g	<input type="checkbox"/> MRC-Contracted Services	Program: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____
h	<input type="checkbox"/> Employment	Employer: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____
i	<input type="checkbox"/> School <input type="checkbox"/> Ch.766-Special Education	Program: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____
j	<input type="checkbox"/> Other (specify)	Program: _____ Contact: _____ Daily Schedule: _____	Dates: _____ Telephone No.: _____